Working with deaf adolescents on SRHR in Rwanda

Case study

VSO undertook an internal learning exercise of work with deaf adolescents on sexual and reproductive health and rights in Rwanda. The fieldwork was carried out in November 2018 and the content of this case study is drawn from this fieldwork and supplemented with a small scale secondary research exercise. A total of 40 stakeholders participated in the primary data collection exercise in Nyagatare in the Eastern province of Rwanda.

Executive summary

Overview

The aim of this learning exercise was to understand how the project has progressed, the strengths of the work, the challenges experienced, and to understand the changes brought by the project. It also aimed to explore in depth the components of the project and reflect on their value and potential replicability for future programming.

The project aimed to improve sexual and reproductive health and rights (SRHR) for deaf adolescents and youth through:

- The provision of basic sign language training offered to nurses and community health workers to break the communication barrier between providers and deaf clients in relation to family planning and general SRHR service provision.
- Raising awareness of SRHR issues amongst deaf youth and adolescents through sessions in the local deaf school and out of school in skills workshops (tailoring, hairdressing, barbers) where young deaf people are putting skills into practice.
- Community outreach to raise deaf awareness in the community and also support young deaf people without sign language to develop sign language skills.

Findings

Health care workers spoke very highly of the training they had received. There was some variation amongst participant in the number of days training and the length over which these days were spread but no clear consensus emerged as to preferences. Many felt that there was need for refresher training or some mechanism to practice and continue learning sign language.

Health care workers said that the training had helped them to overcome their fears and inhibitions and increased their confidence to work with deaf clients and their parents. Some also talked about how the training had challenged their preconceptions about deaf people and increased their awareness of deaf people in the community.

Whilst participants highlighted that the sign language had helped them to communicate with deaf people in the community there are also deaf people in the community who do not speak sign language. They also identified a need for more visual materials.

Deaf young people commented that accessing health services had been very challenging before the nurses had learnt sign language but now they are able to access a nurse without an interpreter. They also said that the community health workers had also not been able to help to explain how to access health services but this has now improved. There was a reported uptake of the use of clinics by deaf young people which reflects in increased awareness and confidence. Also community health workers often accompany deaf youth to the clinic which can be very helpful if the nurse they see has not received training.

Being able to use sign language has helped to build trust with deaf young people and also their parents. Health care workers also said that enhanced communication has helped to identify issues making diagnosis easer which in turn makes treatment and referral more effective.

Participants provided examples of how health care professionals had used their sign language skills to identify pregnancy, identify gender based violence, support family planning, encourage HIV

testing and treatment and provide support on general health matters and issues beyond this such as accessing ID cards.

The national volunteer's SRHR sessions in the deaf school are popular with the students with class sizes varying from between 20 and 30 students. The sessions are practical and teachers had observed an increase in knowledge and awareness on SRHR amongst students. It was felt to be very important that the volunteer is deaf as she is a significant role model for young people in the school and the deaf students were perceived to have responded very well to her.

The work undertaken by the volunteer in the community has helped to engage hard to reach groups who often do not speak sign language and has also raised awareness amongst parents of deaf young people. Deaf young people reported that they have learnt a significant amount of SRHR information which was new to them.

The national volunteer has played an active role in work beyond the community and this has had strategic influence. It was highlighted that it is significant that a deaf volunteer is playing such a pivotal role in the work as it acts as an example of good practice for other organisations.

Recommendations

- Delivering the range of dimensions of work with health care professionals and young people has been important to achieving overall impact.

- Sign language skills require practice in order to be maintained and it would be valuable for those trained to come together to practice and also refresher training would also be useful.

- It is important to ensure that those health care workers trained are well spread across facilities and their skills can be drawn upon as and when they are needed. It is also important to recognise however that this may mean they are taken away from their regular role in an ad hoc fashion in order to interpret for colleagues and those managing them need to be aware of this dynamic.

- There is a stronger argument for training all, or at least a higher proportion of community health workers in sign language as they have closer day to day contact with a broader cross section of the community and are more likely to come across deaf people needing to access health services on a regular basis. If they can support deaf people to access the services they need and accompany them, they may be able to act as interpreters if the health care professional does not have sign language.

- There was no clear consensus on the best way to deliver sign language training to health care workers. Some expressed a preference for block training and others said they would have preferred a number of shorter blocks with a gap in between. If feasible it might be worth offering both options in future.

- It would be useful to consider developing a short deaf awareness training course that could potentially be delivered to all health care professionals to raise awareness, break down the stigma and provide information about resources. This could be delivered using a train the trainer approach with those who have some experience of working with deaf patients being trained as trainers.

- It would be valuable to run a deaf awareness event in the local community to extend the reach into the community. It would also be useful to bring together health care workers with young deaf people for a dialogue to share information about services and for young people to talk to health workers about what they need from health services.

- There is a strong case for working with out of school deaf young people because of the multiple challenges that they frequently face. It would be useful to work with peers (training young deaf people to train sign language to peers who have not learnt to sign).

- Livelihoods work could be strengthened by expanding opportunities with the peer educators to explore career pathways. It may be worth exploring employment opportunities in other areas beyond those currently offered by the workshops.

- It would be useful to further explore the promotion of the work at conferences/learning papers etc. There are a number of research opportunities that emerge from this work which could be the subject of bids for research grants/funding and these include:
    - The role of community health volunteers as a bridge
    - Barriers faced by young deaf people
    - Behaviour change amongst parents/health care workers.

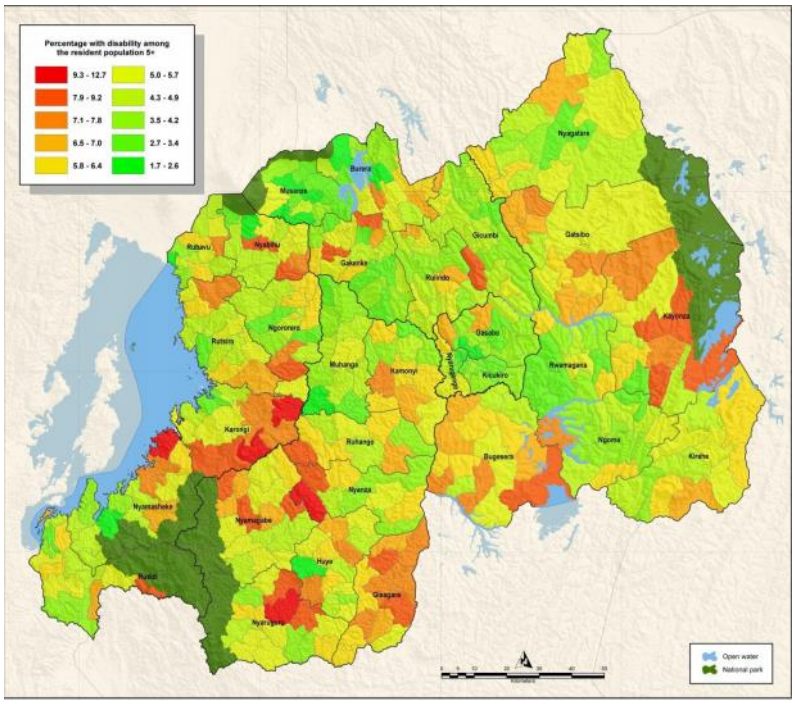
Introduction

The aim of this learning exercise was to understand more about how the project has progressed, the strengths of the work, the challenges experienced, and to understand the changes brought by the project. It also aimed to explore in depth the components of the project and reflect on their value and potential replicability for future programming in Rwanda and also in other countries where VSO also delivers adolescent and youth sexual and reproductive health and rights interventions.

Context

Figure 1 below show the prevalence for disability in Rwanda at sector level for those aged five and over. There is difference in disability prevalence rates observed for urban and rural areas with the lowest prevalence rates found in districts with a large urban population. This is the case in Musanze district (Northern Province) with 3.3% of people affected by disabilities, the three districts of Kigali City with 3.2% to 3.4%, Muhanga (3.8%; Southern Province), and Rwamagana (3.9%; Eastern Province). The highest concentration of persons with disabilities can be observed in Gisagara (6.8%; Southern Province) and Karongi (6.5%; Western Province).[1]

Figure 1 prevalence for disability in Rwanda at sector level for those aged five and over.



The WHO estimate that around 466 million people worldwide have disabling hearing loss, and 34 million of these are children. It is estimated that by 2050 over 900 million people will have disabling hearing loss.[2] In Rwanda the prevalence rate for those with hearing loss is 0.4% and figure 2 below shows the number of people affected by hearing loss and figure 3 shows their percentage among the resident population (prevalence) by province and area of residence for age 5 years or above.

[1] National Institute of Statistics of Rwanda, Thematic report, Socio-economic characteristics of persons with disabilities: Fourth population and housing census Rwanda 2012

[2] WHO factsheet on deafness and hearing loss (March 2018)

Figure 2 - The number of people in Rwanda affected by hearing loss by province and area of residence for age 5 years or above.[3]

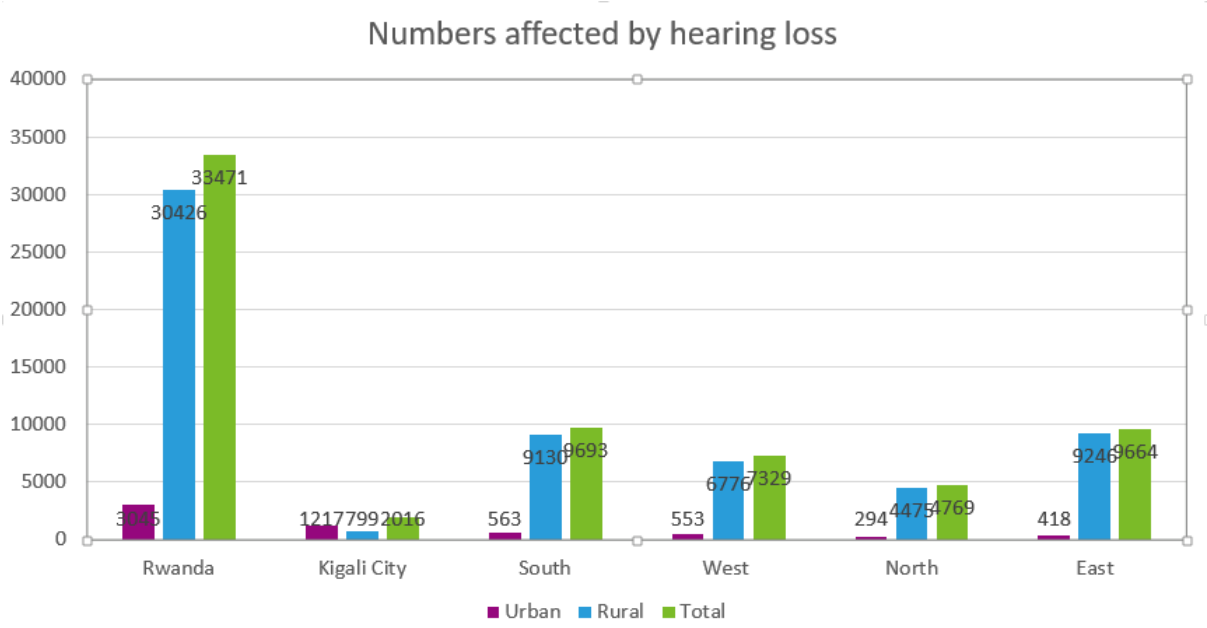
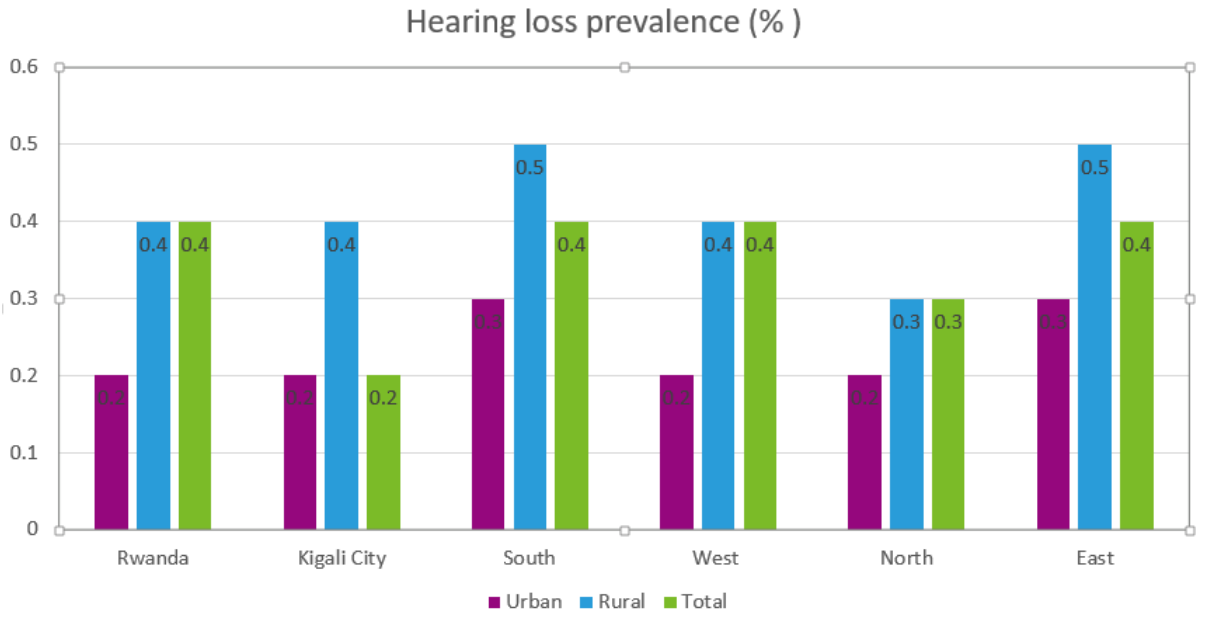


Figure 3 – The percentage of the resident population (prevalence) in Rwanda affected by hearing loss by province and area of residence for age 5 years or above.[4]



[3] Data extracted from National Institute of Statistics of Rwanda, Thematic report, Socio-economic characteristics of persons with disabilities: Fourth population and housing census Rwanda 2012

[4] Data extracted from National Institute of Statistics of Rwanda, Thematic report, Socio-economic characteristics of persons with disabilities: Fourth population and housing census Rwanda 2012

The sexual and reproductive health and rights of deaf young people is generally an under researched area. A study focusing on HIV information and services for young people with disabilities in Rwanda and Uganda found that the barriers preventing adequate access to information about HIV and AIDS experienced by adolescents with disabilities depended on the nature and severity of the impairment. For example, parents and health workers were unable to communicate with deaf adolescents using sign language, adolescents with physical impairments were often unable to access community meetings about HIV and print material was not adapted for those with visual impairments. Further, assumptions by health workers and community members that people with disabilities were not sexually active lead to the marginalisation of disabled people from HIV services. Adolescents with disability described low self-esteem and issues of self-efficacy affecting control of safer sexual relationships. A high level of targeted abuse, rape and exploitation was reported leading to vulnerability among this population.[5]

Similar findings have also emerged from studies in other African countries. Studies from Ghana on sexual and reproductive health of the deaf indicate that health professionals were unable to communicate effectively with their deaf clients, with a negative impact on the quality of healthcare.[6] [7]. Another similar study in Ghana identified that obstacles are primarily associated with communication, but issues such as privacy and confidentiality at SRH centres, illiteracy amongst deaf people, ignorance of deaf people's needs, negative attitude towards deaf people, interpreters' competence, and limited time for consultation have also contributed significantly in making health information and services inaccessible to the deaf community. Findings from the survey indicated that the level of knowledge on SRH issues amongst deaf people, particularly amongst adolescents, was low, possibly due to limited access to professional sources of information.[8]

A study looking at the perceptions of deaf youth about their vulnerability to sexual and reproductive health problems in Masvingo District, Zimbabwe identified that perceptions about vulnerability to sexual and reproductive health problems are mainly shaped by sexual socialization rather than sensory conditions. Understanding the factors which influence the perceptions of deaf youth about

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[5] A. K. Yousafzai, K. Edwards, C. D'Allesandro & L. Lindström (2005) HIV/AIDS information and services: The situation experienced by adolescents with disabilities in Rwanda and Uganda, Disability and Rehabilitation,27:22, 1357-1363, DOI: 10.1080/09638280500164297

[6] Mottram V, 1999, 'A community forgotten: Deaf people in health care', *Student British Medical Journal* 2000(7), 394–436, viewed 30 September 2010, from http://archive.student.bmj.com/issues/99/10/life/380.php

[7] Margellos-Anast H., Hedding T., Perlman T., Miller L., Rodgers R., Kivland L. et al. ., 2005, 'Standardized comprehensive health survey for use with deaf adults', *American Annals of the Deaf*150(4), 388–396, viewed 10 August 2008, from http://web.ebscohost.com.proxy.cc.uic.edu/ehost/pdfviewer/pdfviewer?vid=3&hid=25&sid=ffaeeb42-40ed-49d6-81e0-ecd946880168%40sessionmgr13 [PubMed]

[8] Wisdom K. Mprah, Sexual and reproductive health needs assessment with deaf people in Ghana: Methodological challenges and ethical concerns Afr J Disabil. 2013; 2(1): 55. Published online 2013 Sep 6. doi: 10.4102/ajod.v2i1.55

sexual and reproductive health problems is significant mainly because the sexuality of people living with disabilities is poorly understood and neglected thereby putting them at risk of sexual and reproductive health problems as well as exposed to sexual violence. The study recommended that the government adopt a human-rights approach to the provision of sexual and reproductive health services to ensure universal access information and inclusivity.[9]

Project context

In 2017 Voluntary Service Overseas (VSO) supported by the Department for International Development (DFID) piloted an intervention informed by a rapid context analysis to improve quality family planning delivery to deaf adolescents and youth aged 15-24 in rural Nyagatare (located in the Eastern province).

It is estimated that in the area covered by the intervention there is a population in the region of 600 deaf adolescent and young people. They experience barriers to accessing sexual and reproductive rights linked to stigma and discrimination, access to information, access to services and limited livelihood opportunities. The project aimed to improve sexual and reproductive health and rights (SRHR) for deaf adolescents and youth through:

- The provision of basic sign language training offered to nurses and community health workers to break the communication barrier between providers and deaf clients in relation to family planning and general SRH service provision.
- Raising awareness of SRHR issues amongst deaf youth and adolescents through sessions in the local deaf school and out of school in skills workshops (tailoring, hairdressing, barbers) where young deaf people are putting skills into practice.
- Community outreach to raise deaf awareness in the community and also support young deaf people without sign language to develop sign language skills.

Sign Language training for health care workers was offered three days per week in period of two months although this varied somewhat across different cadres. It was both theoretical and practical in nature, covering the basics of every day health and life, numeracy and literacy to be used in family planning and SRHR. Training was facilitated by a VSO deaf volunteer and qualified Sign Language instructors from the deaf school and Rwanda National Union of the Deaf. All facilitators had SRH knowledge. Materials used had been developed by Rwanda National Union of the Deaf and UNFPA, and approved by Rwanda Biomedical Centre. Trainers made participatory observation to oversee how Sign Language was used to deliver family planning/SRHR services and gave feedback.

In the period of one year (2017- 2018), the project has reached 250 deaf adolescents and youth with sexual and reproductive health information and capacitated 147 community health workers and 44 nurses with basic sign language skills to enable them open a conversation with deaf young people. It has also engaged approximately 3000 parents and community members with deaf awareness and SRHR messages and supported ten deaf youth vocational graduates with additional practical skills as well as materials to startup business which enabled them to start up production and other service industries like saloon and beauty therapy.

[9] Rusinga O Perceptions of deaf youth about their vulnerability to sexual and reproductive health problems in Masvingo District, Zimbabwe. Afr J Reprod Health. 2012 Jun;16(2):271-82.

Approach to the learning exercise

Overview

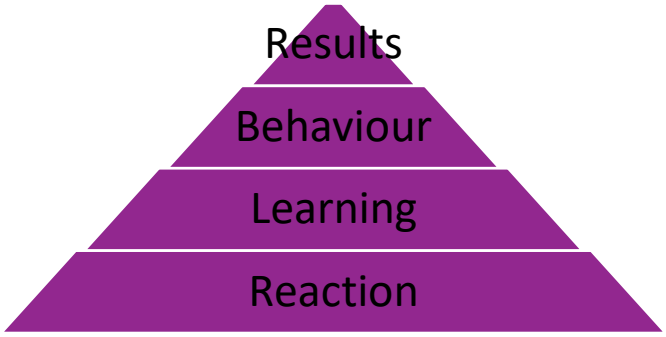
An internal learning exercise was carried out in November 2018 by an evaluation team comprising the Research and Evaluation Specialist for Health and the Global Adviser for Health and supported by the Health Technical Adviser for Rwanda and the Health Project Manager for Rwanda. The process was also supported by a Rwandan sign language interpreter.

A total of three days fieldwork was carried out which included interviews with the following stakeholders:

- Health programme manager
- Volunteers
- Nurses trained in Sign Language
- Community health workers trained in Sign Language
- Young deaf people

The framework for capturing data was based on Kirkpatrick's model[10] which is an established standard for evaluating the effectiveness of training and considers the value of training across four levels:

- Reaction – evaluates how those being trained respond to the training
- Learning – evaluates if those being trained have learnt from the training
- Behaviour – evaluates whether those trained use any learning in the community
- Results – evaluates what changes as a result of those trained using their learning



A key component was to capture perspectives from young deaf people on the impact that training on sexual and reproductive health and rights and training of health care professionals in sign language and has had on their service access and service use. The following learning questions were developed to explore this.

Learning questions

- What are the barriers for young deaf people in accessing and using SRHr services?
- How effective was the training that was delivered through the pilot?
- Has the training resulted in changes in practice for health care professionals?

[10] Kirkpatrick, D. L. (1994). *Evaluating training programs: the four levels*. San Francisco: Berrett-Koehler

- What impact have changes in practice had on the experiences of young deaf people in accessing and using SRHR services?
- Has the pilot resulted in any unexpected change?
- Are there areas for improvement or gaps in the pilot that could inform future work in this area?

Sample size

Table 1 below show a breakdown of the stakeholders that took part in the exercise

Table 1 -Sample size breakdown by stakeholder group

Stakeholder type	Method	#Female	#Male	Total
Community health workers	Focus group	4	9	13
Nurses	Focus group	4	10	14
Teacher at deaf school	Interview		1	1
Volunteer	Interview	1		1
Deaf youth	Focus group	6	4	10
Programme manager	Focus group	1		1
Total		**16**	**24**	**40**

Limitations

Fieldwork time for this work was limited and with more time it would have been valuable to run separate focus groups and interviews with young people in the deaf school who have attended SRHR sessions run by the volunteer to gain their perspectives on the session and understand what they have learnt and if this has influenced any behaviour change. Similarly it would have been useful to run a separate group with deaf young people who have attended sessions in the community. The focus group with deaf young people included both those in school and those out of school and so it was not possible to disaggregate the data.

With more time it could have also been useful to talk to community members and parents of deaf young people anything that may have changed for them as a result of the work of the volunteer.

Some of participants in the focus group with young people did not have sign language and were supported by other deaf young people in the group to communicate. The data could have been enriched if there had been the opportunity to supplement it with a small number of more in-depth interviews with some young people who have sign language.

Findings – training for health care professionals

Training and learning

Training structure

There was some variation in the amount of training that had been received by health care professionals. Initial sessions were for health care worker supervisors and they received a total of 12 days training which was delivered in one solid block. Sessions for some of the non-supervisory community health care workers had been much shorter – some reported receiving a total of five days training. Nurses received a total of 12 days training which was delivered for four days a week over three weeks. Some nurses liked this because it meant they were still able to carry out their nursing duties once a week and the breaks were helpful. Other nurses however felt it would have been better to have a complete break from their nursing roles to receive the training. They found it quite exhausting to have to learn after working. Some had come to the training from a night shift which was especially challenging. Some felt that it would have been preferable for the training to be residential to help avoid the distractions of work. There was a general feeling from some participants that it would be good to harmonise the training so all receive the same input.

Some felt that the training could have benefited from being a greater number of days as they were very motivated and keen to learn. The volunteer involved in delivering the training also commented that time was quite tight to achieve what they were aiming for. Some said that it had been quite challenging to remember the things that they had learnt especially for those that had had not had much opportunity to practice regularly and maintain their skills. The training required a lot of effort and concentration over the period of the training. Whilst a few community health workers liked the intensive nature of the 12 days of training, others felt that it took them away from the communities for too long. There was a suggestion made that training could be delivered in blocks of four days with three days break in between each block to enable them to study the manual and practice.

Training content

Training covered the alphabet, food signs, parts of the body, how to go to the toilet, health related signs linked to the SRHR and other health services they provide at village level, how to explain the treatment provided by them, disease and pain signs such as headache, stomach ache and signs needed to work with pregnant deaf women and to provide referral to clinic based services.

They had received training manuals containing the alphabet, numbers, pictures related to SRH which they felt was really helpful reference material.

The national volunteer involved in delivering the training reflected that within the time they had it was quite intensive to explain the signs needed to be able to communicate about SRHR. She also commented that it was quite difficult to pitch the training correctly to groups because different participants learnt at a different pace.

Training delivery

The training was delivered by two trainers for each group – one hearing and one deaf. The deaf trainer instructed in sign language and the hearing trainer translated and explained. Participants felt that this approach worked very well. They also appreciated that there was plenty of time and space

for trainees to ask questions at all stages of the training. They felt that the training design could have been enhanced by the introduction of games and movies to the curriculum and some felt that the groups would have benefited from being a little smaller to create more opportunity for individual attention.

Gaps

Many said that they are keen to increase their level of knowledge of sign language so the training has certainly created a motivation amongst those trained. So far they haven't received any refresher training but would very much welcome this.

Health care professionals said that whilst the training had proved useful for communicating with deaf clients who speak sign language, there are others that do not speak sign language. Some sign language training has been offered to some young people who do not sign (10 days training has been delivered to 100 young people) but participants felt that there was a need to extend this training to more deaf people.

> *"Training is important. We were never able to help deaf people before but there is still a challenge as some deaf people don't know sign language"* [Nurse]

The national volunteer felt that the work could be enhanced by increasing training for nurses and community health workers and providing more specific learning materials and tools for SRHR such as family planning. She also felt there is a need for more sign language support materials such as videos, books and teaching aides.

The national volunteer also felt that there is a need for deaf youth to increase their knowledge about menstrual hygiene and it would therefore be valuable to train nurses in how to provide menstrual hygiene management support to the deaf.

Behavioural change

Attitudes and confidence

Health care workers said that the training had helped them to overcome their fears and inhibitions and increased their confidence to work with deaf clients and their parents. Some also talked about how the trained had challenged their preconceptions about deaf people and increased their awareness of deaf people in the community.

> *"The training was good. Before the training I feared to meet the deaf but I got the materials to enable me to manage relationships with the deaf"* [Community health worker]

> *"I had no knowledge about sign language, now there is a change in the way I interact with the deaf"* [Community health worker]

> *"I can now listen to deaf patients and I am a better nurse"* [Nurse]

The national volunteer who was involved in delivering the training found both the community health workers and nurses to be very responsive and keen to learn how to work with deaf youth to access services. She reflected that before the training they did not know how to communicate but in just a few days they increased their awareness about the deaf community and learnt the basic sign language needed to communicate about SRHR.

> *"Before the training in sign language the health workers didn't know how to deliver SRH services to deaf youth. This resulted in a lack of support especially for pregnant deaf girls or deaf youth seeking family planning services. Before the training health workers did not meet with deaf people but the training has changed all that. Health workers have changed their behaviour."* [National volunteer]

Deaf young people commented that accessing health services had been very challenging before the nurses had learnt sign language but now they are able to access a nurse without an interpreter. They also said that the community health workers had also not been able to help to explain how to access health services but this has now improved.

> *"When I got sick it was hard to get medicines or to communicate. It is better now the community health workers have received sign language training*" [Deaf youth]

> *"I went to a trained community health worker for medicines and was able to tell her what I needed"* [Deaf youth]

Building trust

Being able to use sign language has helped to build trust with deaf young people. Health care workers also said that enhanced communication has helped to identify issues making diagnosis easer which in turn makes treatment and referral more effective:

"It came at the right time…previously we couldn't help when parents brought their deaf children to us…but now we know how to find out the problem and refer for treatment" [Community health worker]

One young women explained how she has met with three community health workers in her community who have learnt sign language.

"I feel happy and confident that if I get sick there is someone there who can help me" [Deaf youth]

In some cases health care workers described how the trust built has meant that they are now approached for support beyond health:

"We have built relationships with deaf people, they trust us now, they come to us for help to access services even beyond the health sector" [Community health worker]

"I have become a communication and interpretation specialist. I live near the deaf school so am often called upon to negotiate on students behalf with shopkeepers and motorcycle taxis for example". [Community health worker]

Building links between health care professionals

Community health workers often accompany the young deaf person when making a referral to the nurse and this also makes things easier for the nurse especially if they have themselves not received the sign language training. It was also reported that nurses without sign language proactively call upon trained community health workers when they have a deaf patient. In some cases the training has enhanced joined up working from community to facility level. One example was given of how a community health worker had referred a young pregnant women to a nurse who was herself trained in sign language and she became the linked nurse for the patient.

Increased uptake of services

Health care workers reported that deaf young people are now attending the clinics more frequently. They felt that this is because they feel more confident that they will receive a friendly reception. One nurse mentioned that a deaf relative of hers is now more confident, knows he has the right to SRHR information and is much better able to express himself.

"He is now empowered to make SRH choices like any hearing person" [Nurse]

Results and sustainability

Stigma

One of the impacts of the training is that it has helped to break down stigma. Young deaf people and their parents now feel able to bring themselves to the health centres because there are people trained to help them. There is greater trust and improved relations between parents, the deaf youth and the nursing staff. The importance of breaking down stigma were emphasized by the national volunteer:

> *"Societal challenges are the greatest. People think deaf people cannot work because of a lack of knowledge. There is a lot of stigma."* [National volunteer]

Pregnancy

Participants were able to describe specific examples of how they had used their sign language skills to support positive SRHR outcomes for young people. One community health worker was able to communicate with a young deaf woman and establish that she was pregnant and needed ante natal care, and was able to share this with nursing staff who were then able to treat her.

In another case the community health worker reported he had been able to help a young deaf girl understand the risks attached to pregnancy and the risk of falling pregnant when meeting young boys. He helped her to have a pregnancy test which was negative and conducted follow up counselling with her and her parents.

Family planning

An example was given where a family wanted the deaf young person to get family planning but the young person said that she did not want it. Once the community health worker had explained about family planning to the deaf youth she made her own decision and agreed to be placed on short term three month contraceptive.

Another example was given of a deaf woman who was able to ask to change her family planning method. She had been given an implant that would last for five years but she was able to make it understood that she wanted it removing and to explore other family planning options with the nurse instead.

HIV testing and treatment

A nurse reported that two deaf couples had come to the clinic for ante natal care but were also persuaded to have HIV tests too. The nurse was able to communicate why the test was important. Both couples were found to be HIV positive and were able to be placed on treatment to reduce the risk of infection to the baby and also to ensure their own health. They established a good relationship with their nurse and now attend the clinic regularly and are happy to be on anti-retroviral treatment.

Gender based violence

One community health worker reported how they and a nurse who was also trained in sign language had worked together and were able to identify, support and provide treatment to a 19 year old deaf girl who had been subjected to gender based violence.

Support with general health issues

A nurse talked about how she had advised a deaf women about how to adhere to the correct drug regimen when it was discovered that she had been taking her medicine incorrectly.

Another example was given of how a 19 year old deaf boy had been sick for a long time but it was only when he was seen and referred by a community health worker that it was established that he had malaria and successfully treated quite quickly.

One young woman mentioned that her parents were unwilling to believe she was sick. Even when she convinced them she was then initially refused treatment because the nurse was afraid of her. Finally the nurse asked the acting sister to intervene when it was discovered that she was a staff member who had been trained in sign language. The sister was able to treat her and subsequently referred her to the national volunteer who is now supporting her to learn sign language.

Advocacy

One community health worker talked about how she had become an advocate for deaf children as a result of the training. A neighbour had a six year old deaf child who was not well treated. The community health worker spoke to them about the training she had received from the deaf volunteer (who was also a university graduate) and how deaf people can succeed and become role models for everyone. The parents came to see how their own child could achieve the same and changed their behaviour as a result.

As a result of the training the community health workers have worked with the national volunteer to reach the parents of deaf youth to help them communicate with their children about SRHR.

An unexpected benefit of the training is that community health workers have also been able to help deaf young people to access national ID cards. These cards are very important in Rwanda as they are required in order to be able to access health services. Previously even though they had health insurance young deaf people were unable to explain this to health workers. But many deaf young people also do not have health insurance so were denied access to services as a result and stayed at home even when they were sick.

Supporting colleagues

For those who have been trained in sign language the training has helped them in their practice and they are now called upon to support colleagues who have not been trained when they have deaf patients. This is a positive thing but can create a greater workload for individuals.

> *"It created an opportunity for me but also extra work. As I am a midwife I get called to help colleagues understand deaf pregnant women. We need more health workers trained"* [Midwife]

> *"I went to a health centre and in the consultation room I found a nurse who took me to another nurse who had been trained in sign language. I got the medicines I needed as a result"* [Deaf youth]

One example was given by a nurse who intervened when she saw that a colleague not trained in sign language was struggling to provide good treatment to a deaf pregnant woman. The nurse was able to establish that the deaf woman was able to write down what she wanted so the untrained nurse could still communicate with her and provide the correct treatment.

Challenges and areas for improvement

Nurses observed that after receiving training that they are better equipped to work with deaf patients that present in the clinic but more needs to be done to reach out to the deaf people in the community who are not using health facilities. Community health workers said that they recognize that there deaf young people in the community who cannot sign are very isolated and in need of sign language training. They also identify potential peer educators amongst the deaf youth they interact with, who can potentially be trained to strengthen the links between service providers and the deaf community.

Health care workers said that they would value more visual materials to extend their ability to communicate more effectively with a wider number of deaf patients.

Some commented that there are challenges in retaining the things learnt during the training especially for those who do not have much opportunity to practice. They felt that it would be useful to have group meeting where those trained could come together and practice sign language on a regular basis. Other suggestions to overcome this challenges were follow up visits from the deaf trainer and refresher training to help them re-learn what they may have forgotten and to help them increase fluency.

Health care workers felt that it would also be useful to hold deaf awareness days in villages/sectors and encourage the deaf sign language volunteer to take part as she is such a good role model. This view was also held by deaf young people:

> *"VSO should work more with the parents of deaf youth to reduce stigmatisation of their children."* [Deaf youth]

The national volunteer also felt there was a need to facilitate more meetings between health workers and deaf community to increase understanding and to discuss issues that affect them. She

also felt that there was potential to use the Theatre for a Change approach in in this context to raise awareness.

Findings – SRHR awareness raising sessions in deaf school

The national volunteer has been delivering SRHR session in the deaf school on a regular basis throughout her placement. The course is extra curricula with specific hours after school set aside for delivery. Her sessions are age appropriate with SRHR education starting with children from the age of ten years old. Because the classes are extra curricula the volunteer is able to bring together students from across classes for her sessions. She uses videos, diagrams and visual aides to help convey messages. The sessions are popular with all the students with class sizes varying from between 20 and 30 students.

> *"The students are very open and keen to learn. They want to know which behaviours to change and about their SRH rights"* [National volunteer]

The volunteer has skills in business development and also provided some training in this which has appealed to the young people in school and some young people said they would benefit from more of this:

> *"VSO could provide more skills training to deaf youth in carpentry or dress making to help deaf young people"* [Deaf youth]

In addition to this direct work with students the volunteer also supports teachers in classes with sign language interpretation. It should be noted however that not all deaf children can access the school due to the cost of boarding fees and school materials costs.

It was felt to be very important that the volunteer is deaf as she is a significant role model for young people in the school and the deaf students were perceived to have responded very well to her. Her skills have been recognised and valued by her colleagues:

> *"She is a born teacher. She has the gift of good preparation and is a talented artist. She uses excellent methodology including appropriate use of her face and body to get messages across"* [Deputy head teacher]

It was also mentioned that she has the ability to work with all students, irrespective of their level of knowledge which has been particularly valuable in this role.

Previously girls who attended the school became pregnant when they left because sex education was insufficient in that they only talked about the biological facts of SRH. The deputy head teacher feels that the new extra curricula SRHR lessons provided by the national volunteer are much more practical because they also include life skills training, information about family planning and birth control, condom use, disease causation and prevention (especially HIV and STIs).

The deputy head teacher used to hold sessions with the boys about relationships, condom use, how to show respect to partners when he felt they were ready to receive this information. He has observed that since the national volunteer has been running sessions the boys ask different questions. They are more confident and less secretive about expressing their feelings. Both boys and girls now demonstrate a greater understanding of the importance of using protection to prevent HIV and STIs and understand the importance of family planning.

Findings – SRHR awareness raising in the community

The national volunteer has been undertaking sessions in the community in a range of ways.

- She has been running SRHR session for deaf young people who are not in school this has been done though the workshops that have been set up to support deaf youth with skills training
- She has identified young deaf people in the community who do not speak sign language and has run sessions with them to teach them sign language
- She has worked with the broader community and parents of deaf young people to raise their awareness

Participants felt that in the same way that the volunteer acts as a positive role model for deaf students in school this also applies to deaf young people in the community. The volunteer herself is very aware of her responsibilities as a role model:

> *"I lead by example, using a variety of ways to communicate such as sign language, writing and drawing. But still people fear deaf people"* [National volunteer]

She is also able to raise awareness amongst parents of deaf young people and challenges their views about what their children can achieve through her own example.

"Some parents believe their deaf children have no future. It can be difficult to communicate with some deaf youth because they don't know sign language" [National volunteer]

The volunteer has been able to reach hard to reach groups in a remote area through her outreach work which was not initially included in the scope of her work. She has taken it upon herself to undertake this work driven by her own passion and commitment.

The volunteer reflected that working with youth outside the school setting is much more difficult because they often don't know sign language. This limits her ability to explain SRHR to them easily, especially if the parents also don't know sign language or how to communicate with their deaf children. It is very common for deaf children never to receive schooling.

Findings – change for deaf young people[11]

Young people said that before contact with the volunteer they did not know about SRHR or related sign language. Now they know the correct signs to use but have also realized that they can also express their needs to nurses in writing too.

> *"Before I didn't know any sign language. Now I can communicate when I am sick"* [Deaf youth]

> *"She* [national volunteer] *taught us the signs we need to know to explain how we are sick"* [Deaf youth]

Learning and knowledge levels varied significantly amongst participants which is a reflection of their starting point, also a number of participants were not confident in sign language so the volunteer's focus with this group had been to build their confidence with sign language.

Participants reported that they had learnt about bodily changes that occur during adolescence and this information was something new to them. They had also learnt about how to prevent pregnancy, family planning and how to prevent HIV, about HIV treatment such as post exposure prophylaxis and anti-retroviral therapy and about how to recognize and treat STIs and the use of condoms. They had also learnt about menstruation. Many said that much of the information was new to them and they had not had the opportunity to learn this anywhere else. They had also received materials to support the sessions and information about where to go to ask for help.

[11] Because deaf young were all in the same focus group it has not been possible to desegregate the data to understand which data came from those attending session in school and which came from those attending sessions in the community.

"I didn't know about STIs before. She used pictures to explain different diseases, the symptoms and how to protect ourselves" [Deaf youth]

"*Before training, us deaf people, we didn't know how you got pregnant."* [Deaf youth]

"She taught us how to use sanitary pads, before we didn't know. Also to understand about menstrual periods and symptoms and about how to access medicines to reduce discomfort." [Deaf youth]

"She explained about wet dreams and why boys experience this" [Deaf youth]

"Without this knowledge we were at risk. Now we know how to use condoms and make informed decisions about our SRH" [Deaf youth]

"Before I didn't know signs relating to SRH. I have learnt about bodily development, the process of moving from childhood to adulthood and how to realise my right to SRH" [Deaf youth]

Participants felt quite strongly that it would be useful for them to come together and share learning:

"VSO should hold more deaf community meetings so that the young people can come together and learn from each other." [Deaf youth]

Findings – Outcomes beyond the community

The national volunteer has played an active role in many activities beyond her work in the community which has included attending both internal and external conferences. It was highlighted that it is significant that a deaf volunteer is playing such a pivotal role in the work as it acts as an example of good practice for other organisations.

"VSO is showing other organisations that it is possible for a deaf person to be deployed in an important role." [Deputy head teacher]

Participants commented that the work of the volunteer and VSO is having an impact at a more strategic level. The Government is starting to pay attention to this work and the volunteer is playing a key role in breaking down barriers with government health providers.

Challenges

One of the most significant issues for deaf young people is that it is possible to increase their awareness and knowledge about SRHR but they can still face significant challenges when they access services. It is for this reason that the project has tried to take a two pronged approach to addressing this. It was felt that there may some potential to consider how phone apps could be used to support communication and learning with the deaf community.

A challenge identified with the work is that it could potentially create a dependency on VSO or the project or possibly the volunteer as the project will have a finite lifespan. There is a need to encourage those involved such as nurses and community health workers to self-learn, self-sustain and to practice sign language. This needs to happen to ensure sustainability once the project has ended.

It can be a challenge to change the mind set of parents of deaf youth who don't see their deaf children as having the same rights or same capabilities as hearing children. Some participants commented that there was reluctance amongst some to accept that youth can learn sign language or should learn about their SRHR.

> *"Deaf young people are very isolated. Many don't know sign language, are ignored by their parents, have no awareness of SRH and find it very difficult to get health care. VSO should try to reach more young deaf people and help them get out of their isolation"* [Deaf youth]

Participants felt that one of the challenges is that the project is perhaps still seen as less important than some other work because it reaches a smaller population even though it is targeting a excluded groups.

Whilst the project has covered some ground participants expressed views about extending the scope of the work to cover other important areas in more depth such as menstrual hygiene management and gender based violence. Equipping deaf young people to understand about forced sex and gender based violence could help avoid it, recognize when it occurs or is threatened, report incidences and know their rights.

> *"These are key issues and many deaf people do not know about these."* [National volunteer]

Recommendations

The project has taken an effective approach to work on raising deaf awareness in the community and at the same time raising SRHR awareness amongst deaf young people. Delivering only one of these dimensions would appear to have been far less effective in terms of overall impact compared to approaching both areas.

Some of the health care workers trained have struggled to practice their skills and this has largely been due to not having the opportunity to put their skills into practice. Sign language skills require practice in order to be maintained and it would be valuable for those trained to come together to practice and also refresher training would also be useful.

It is unrealistic to imagine that a project of this scale will be able to train all clinical staff in sign language and it could be argued that this would not be the most efficient use of resources. Of key importance is ensuring that those trained are well spread across facilities and their skills can be drawn upon as and when they are needed. It is important to recognise however that this may mean they are taken away from their regular role in an ad hoc fashion in order to interpret for colleagues and those managing them need to be aware of this dynamic.

There is a stronger argument for training all, or at least a higher proportion of community health workers in sign language as they have closer day to day contact with a broader cross section of the community and are more likely to come across deaf people needed to access health services on a regular basis. If they can support deaf people to access the services they need and accompany them they may be able to act as interpreters if the health care professional does not have sign language.

There was no clear consensus on the best way to deliver sign language training. Some expressed a preference for block training and others said they would have preferred a number of shorter blocks with a gap in between. If feasible it might be worth offering both options in future.

It would be useful to consider developing a short deaf awareness training course that could potentially be delivered to all health care professionals to raise awareness, break down the stigma and provide information about resources. This could be delivered using a train the trainer approach with those who have some experience of working with deaf patients being trained as trainers.

It would be valuable to run a deaf awareness event in the local community to extend the reach into the community. It would also be useful to bring together health care workers with young deaf people for a dialogue to share information about services and for young people to talk to health workers about what they need from health services.

There is a strong case for working with out of school deaf young people because of the multiple challenges that they frequently face. Many of these young people do not have sign language which means that the starting point needs to be to develop sign language skills as without this it is very challenging to raise awareness on SRHR. It would be useful to work with peers (training young deaf people to train sign language to peers who have not learnt to sign) as this has the potential to:

- Increase the capacity to create impact
- Decrease dependency on national and international volunteers
- Increase reach to people with differing ranges of communication ability

- Offer a range of peer activities including education, befriending, support, navigation

The workshops are useful hub and engage young deaf people who are not in school and offer an opportunity for connections with the hearing community. Livelihoods work could be strengthened by expanding opportunities with the peer educators to explore career pathways. It may be worth exploring employment opportunities in other areas beyond those currently offered by the workshops.

It would be useful to further explore the promotion of the work at conferences/learning papers etc. There are a number of research opportunities that emerge from this work which could be the subject of bids for research grants/funding and these include:

- The role of community health volunteers as a bridge
- Barriers faced by young deaf people
- Behaviour change amongst parents/health care workers.

Conclusion

This project has developed effectively beyond its original scope to train sign language to health care workers and raise awareness of SRHR for students within the deaf school. These original objectives have been delivered as planned and there is evidence that as a result of this attitudes of health care workers have shifted and the stigma experienced by deaf young people has begun to be broken down. There is also evidence that health workers have increased their confidence in sign language and they are using this to the build trust of deaf young people which has resulted in a report uptake of health services by this group. It has also led to health care workers supporting deaf people in the community in areas beyond just health.

The work carried out by the national volunteer in the deaf school has resulted in increase awareness and knowledge amongst those attending sessions across a range of issues including preparing for physical changes associated with adolescence, pregnancy, family planning, STIs and HIV treatment and prevention and also helped the volunteer to identify other areas that would be useful to include such as menstrual hygiene, forced sex and gender based violence.

The project has however gone way beyond its original intention and this has been possible due to the very significant commitment from the national volunteer and supported by the VSO health team, who are also highly committed to this work. The national volunteer has also delivered awareness training to young deaf people who are not in school and has gone out into the community to identify deaf young people who do not have sign language and has begun to build their sign language skills. Generally the young people who do not have sign language are more marginalised and isolated than those in school so by reaching out to find these young people and then working with them to build skills in sign language and raise awareness in SRHR there are significant impacts which go beyond just health.

The attitude, skills and enthusiasm of the national volunteer have been pivotal in delivering this intervention so effectively. She is an outstanding role model for the deaf young people that she works with but parents of deaf youth are also influenced by her as she challenges perceptions that many hold that children will not be able to achieve things in life because of their deafness. She has also acted as an ambassador and advocate beyond the work in Nyagatare. One of the challenges is however that the project has a heavy reliance on one very strong volunteer although another volunteer has now started and it is hoped that this will help to build momentum of the work and reduce reliance on one person.

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